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National Institute of Mental Health

Assuring Quality Mental Health Services: The CHAMPUS Experience

DoD Funds Psychology Peer Review Project

APA, CHAMPUS Enter Claims Criterion Pact

CHAMPUS

CHAMPUS peer review

Peer Review Project Said Successful to Date

MANUAL FOR OUTPATIENT CLINICAL PSYCHOLOGICAL CLAIMS REVIEW

JAN 29 1982

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
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National Institute of Mental Health

Assuring Quality Mental Health Services: The CHAMPUS Experience

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In Memoriam

MARGARET CONWELL

1919-1980

Margaret Conwell, the NIMH project officer for the SCOPCE peer review described in tnis report, was a pioneer in the mental health quality-assurance field. Her dedication and persistence as a coordinator and nurturer of the newly developing system were instrumental in helping to assure its success.

The mental health people . . . had been referring these kids to RTCs, and it was very hard for them to come to grips with the fact that they'd been referring them to holes.

John Meyer, M.D., M.P.H.*
Lt.Cmd., USNMC

*Navy Medical Corps officer and principal architect of CHAMPUS mental health quality-assurance efforts.

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Foreword

SCOPCE I (Select Committee on Psychiatric Care and Evaluation), the mental health peer review project described in this report, was the outcome of a collaborative effort between the National Institute of Mental Health and the Department of Defense, begun under the stern eye of a U.S. Senate Subcommitteee. Thanks to the conscientious performance of Federal agency personnel and to impressive cooperation by some 70 non-Federal child mental health professionals, SCOPCE I dramatically demonstrated the potential for improving the quality of treatment for children suffering mental health problems.

SCOPCE I grew out of a crisis in the care of emotionally disturbed young people. As a direct result of the project, hundreds of troubled children and adolescents have been spared harm at the hands of inadequate and misguided caretakers, and millions of taxpayers' dollars have been saved. A stigmatizing mark has been erased from the face of residential treatment for emotionally disturbed children, and a unique mental health benefit has been proven feasible within the world's largest unified health benefits plan, CHAMPUS (the Civilian Health and Medical Program of the Uniformed Services).

Moreover, SCOPCE I provided an affirmative answer to an increasingly important and timely question: Can the mental health field police itself? The peer review know-how gained in SCOPCE I will be invaluable to health policymakers, third-party payers, and provider and consumer groups. Indeed, the experience of this project, and that of the burgeoning CHAMPUS mental health quality-assurance efforts that have been its outgrowths, also have significant implications for the construction of peer review systems for the general health field.

Prior to SCOPCE I, no one actually knew with certainty whether a national, multidisciplinary mental health peer review system could be undertaken successfully. Could clinicians be expected to make intelligent judgments about cases simply on the basis of a medical record? Could they find out

what was really happening in a remote facility? Could they be trusted to sit in judgment—even to police—their professional colleagues?

SCOPCE I has demonstrated that all these were possible, and as such deserves the attention of all those concerned with the well-being of America's children.

Herbert Pardes, M.D.
Director
National Institute of Mental Health

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Note

Prior to the peer review experiment described in this report, residential treatment centers (RTCs) for emotionally disturbed children, as institutions, were only vaguely defined. Some programs that called themselves RTCs better resembled boarding homes, while others were more like psychiatric hospitals. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) has since adopted the following definition:

> "Residential Treatment Centers" means institutions (or distinct units of an institution) existing specifically for round-the-clock, long-term psychiatric treatment of emotionally disturbed children who have sufficient intellectual potential for responding to active psychiatric treatment, for whom outpatient treatment is not appropriate, and for whom inpatient treatment is determined to be the treatment of choice. RTCs do not provide domiciliary and/or custodial care, but rather, must be able to provide a total therapeutically planned group living and learning situation within which individual psychotherapeutic approaches are integrated. To be approved by CHAMPUS, private RTCs must:
>
> a. Be accredited by the Joint Commission of Accreditation of Hospitals under the Commission Standards of Psychiatric Facilities Serving Children and Adolescents; and
> b. Have entered into a participation agreement with CHAMPUS which requires that the RTC will comply with the CHAMPUS standards for Psychiatric Residential Treatment Center Serving Children and Adolescents.

Introduction

In the summer of 1974 a scandal rocked the field of residential treatment for emotionally disturbed children. Senate hearings revealed widespread abuse of children and adolescents in psychiatric residential treatment centers (RTCs) around the country. Testimony before the Government Operations Committee's Permanent Subcommittee on Investigations told of children kept in squalor, injected with their own urine, forced to inhale carbon dioxide, buried alive in shallow graves, given massive doses of drugs and vitamins, and confined for days in a basement "dungeon"—in the name of mental health.

Taxpayers had been paying the bills for such "treatments." The residential treatment centers were paid millions of dollars by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the health benefits plan for service families, retired service people, their dependents, and dependents of members killed in action.

Ersatz RTCs had sprouted up around the country to take advantage of the virtually untended garden of CHAMPUS-funded residential treatment benefits. This is the story of the aftermath of that scandal—of the weeding of the garden.

It was apparent that CHAMPUS lacked effective controls on the costs and quality of services for which it was paying. The program was hamstrung in its efforts to root out substandard RTCs because it had no authoritative way of distinguishing legitimate mental health care from quackery.

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Ersatz RTCs had sprouted up around the country to take advantage of the virtually untended garden of CHAMPUS-funded residential treatment benefits. This is the story of the aftermath of that scandal—of the weeding of the garden.

At the end of Senate hearings in August 1974, Subcommittee Chairman Senator Henry M. Jackson requested that CHAMPUS submit plans within a month for establishing controls and accountability in the program, including proposals for "outside bodies which could certify and monitor the performance of institutions funded with CHAMPUS monies."

The Department of Defense (DOD), which administers CHAMPUS, met the Senator's challenge. By September 1974, it had secured the assistance of the National Institute of Mental Health (NIMH) to help develop an independent, authoritative quality-control system for its residential treatment benefit. Within months the system was operational.

Three years later, in 1977, the number of troubled CHAMPUS child beneficiaries in psychiatric residential treatment had plummeted from a one-time peak of nearly 3,000 to about 200. The number of CHAMPUS-approved centers reimbursed for residential treatment was down to 74 from more than 1,000 in 1973. The total cost of the benefit to taxpayers had dropped from $13.5 million in 1973 to less than $4 million just 3 years later. But most important: Thousands of children were better off.

This dramatic turnaround was not accomplished by arbitrarily cutting benefits. Rather, it was largely the fruit of a case-by-case peer review carried out, under NIMH auspices, by an independent interdisciplinary team of child mental health experts. Child psychiatrists, psychologists, social workers, and nurses reviewed hundred of case records and paid unannounced visits to inspect RTCs housing CHAMPUS-supported children.

What they found often appalled them: unfortunate youngsters who should never have been placed in residential treatment, and RTCs that were "psychiatric" in name only. Many of the participating professionals said they felt embarrassed that the mental health field had harbored such a tragic travesty in the name of treatment.

The review project, which ended in the summer of 1977, was known as SCOPCE I (Select Committee on Psychiatric Care and Evaluation). It was a pioneering effort for the mental health

field: the first multidisciplinary mental health peer review ever undertaken on a national scale, and the first system to employ such innovations as unannounced site visits to enforce its own rigorous set of standards, prescreening and preauthorization for payment, and contractual participation agreements with each facility.

For CHAMPUS, SCOPCE I became a prototype for even more ambitious mental health quality-assurance efforts that were to follow. Two more projects enlisted NIMH in a broker role: SCOPCE II, a pilot concurrent peer review system for inpatient treatment of schizophrenic adults, and SCOPCE III, a retrospective review of inpatient claims. Subsequently, in the fall of 1977, CHAMPUS contracted directly with the American Psychiatric Association and the American Psychological Association to develop national peer review capabilites for the two professions.

CHAMPUS has invested millions of dollars in developing its own mental health quality-assurance system—more by far than any other third-party payer.

Indeed, private carriers, most notably AEtna Life and Casualty, have recently begun to adopt the CHAMPUS model for professional peer review of their own mental health claims. The CHAMPUS system is increasingly being touted as an alternative to the PSRO (Professional Standards Review Organizations) system, which has received mixed reviews in recent years as to its effectiveness in controlling quality and containing costs. Whether the CHAMPUS collaborations with the two APAs will ultimately prove their worth remains to be seen. The review systems have been operational for less than 1 year at this writing. Accordingly, this report is devoted primarily to SCOPCE I.

MENTAL HEALTH INSURANCE

Insurance coverage for mental health care has been slow in proving itself to a skeptical insurance industry and a sometimes prejudiced public. Third-party health plans pay twice as much of Americans' physical health bills as mental health bills, according to NIMH estimates. Most limit the number of visits or dollar amounts covered for outpatient care, and many require a higher copayment for mental health services. Many

plans also restrict reimbursement to certain types of professionals (e.g., physicians and clinical psychologists) and to medically accredited facilities.

In part, the lag in coverage is a vestige of an earlier era when most mental health care was provided in large public hospitals. Outpatient benefits are much more limited than inpatient coverage in most plans. Despite the dramatic shift to community-based care over the past two decades, the ratio of public to private funding of mental health care is about 50/50 compared to about 42/58 for general health care (Alcohol, Drug Abuse, and Mental Health Administration 1980). Community mental health centers and other organized care settings still rely heavily on categorical Federal and State support.

Because of the stigma associated with mental illness, employers and unions have typically been under little pressure to increase benefits in group insurance plans. As the President's Commission on Mental Health (1977) pointed out: "The misunderstanding and fear surrounding mental and emotional problems are so great that there is insufficient public support for needed services . . ." (President's Commission on Mental Health 1977). In one study, blue-collar workers shunned mental health treatment, turning to it only as a last resort even though their insurance policy offered free initial visits to a psychiatrist (Glasser et al. 1977).

A modest 0.6 to 2.? percent of insured persons used outpatient mental health benefits for an average of 4.2 to 9.3 visits each year in most plans studied over the past decade or so (Von Korff and Kramer 1979). Still, the insurance industry remains wary of expanding benefits. There are doubts about the effectiveness of mental health treatments, fears that utilization and costs are unpredictable, that mental disorders lead to years of expensive long-term care, and that the mental health field itself cannot agree on diagnoses or appropriate treatment. Many insurers despair of ever being able to ferret out functional persons who enter long-term psychotherapy in search of self-actualization from those whose treatment is "medically necessary."

A long-time insurance industry bugaboo known as "moral hazard" underlies some of this resistance. "Insurance presupposes that the covered situation is likely to be a chance event, uncontrollable by the insured person," explains NIMH psychia-

trist Dr. Steven Sharfstein. "If the insured person finds it 'desirable' to develop the condition for which he has the insurance, it undermines the whole integrity of the insurance system. A dramatic example is setting fire to one's own house in order to collect homeowner's insurance."

CHAMPUS faced a similar problem with RTCs. Parents or State juvenile authorities unable to cope with a problem youngster sometimes found it expedient to have the youngster diagnosed as suffering from an "adjustment reaction to adolescence" so that he could be sent off to a remote RTC at Federal expense.

Public as well as private health care programs discriminate against mental illness in their reimbursement policies. Medicare, for example, imposes a $250 annual limit on outpatient care. Efforts to raise that ceiling recently encountered a unique challenge to the mental health field. A bill was introduced in Congress in 1980 which would raise the limit to $750 per year. However, only those psychotherapies scientifically proven safe and effective would qualify for reimbursement.

Such scientific criteria so far have been applied only to drugs, not to medical procedures; the Food and Drug Administration requires evidence of safety and efficacy from drug manufacturers. Third-party payers have traditionally asked only that a psychotherapy or other procedure represent "usual and customary" medical practice to qualify for reimbursement. Such a determination can be made by the insurance company's own medical department or by submitting cases to a panel of the therapist's professional peers. The implicit assumption is that professionals are trained in efficacious procedures, hence their "standard practice" has an indirect scientific grounding.

The problem in the mental health field is that there are no fewer than 240 different "brands" of psychotherapy (Herink 1980), some of which are presumably more effective than others for certain types of problems—and some of which have gained a reputation for "flakiness." Proponents of requiring evidence of a treatment's safety and efficacy point out that review on the basis of usual and customary criteria tends to stifle innovation in the field and may tend to perpetuate use of traditional yet ineffective procedures (Towery and Perry 1981). Opponents of the movement toward review based on scientific criteria say it would unfairly single out mental health care to meet rigor-

ous standards not demanded of other health care. They also doubt whether the massive cost involved in testing the psychotherapies would actually result in any savings or improve the quality of practice, contending that psychotherapists would opportunistically relabel what they do simply to secure reimbursement.

Whatever its outcome, the recent debate about reviewing mental health treatment efficacy has stimulated renewed interest in professional peer review as a less ambitious albeit more easily developed alternative approach to quality assurance.

MENTAL HEALTH PEER REVIEW: 1974

When is mental health care "medically necessary"? What constitutes appropriate care for a given diagnosis? How long should a treatment last? How much should it cost? Who is a qualified provider? Lacking mental health expertise themselves, third-party programs like CHAMPUS must either arbitrarily impose their own answers to such questions or defer to peer review by mental health professionals. The former alternative—benefit limitations set unilaterally by insurers—has historically encountered resistance from the mental health community. In 1974, first CHAMPUS and then the Blue Cross/Blue Shield Plan for Federal Employees independently attempted to institute major cutbacks in their mental health coverage, which they felt was being abused.

Faced with loss of model benefits in the two bellwether plans, mental health provider and consumer groups joined forces and succeeded in preserving the benefits in exchange for a promise to help the third-party payers control costs and assure quality in the future. The field was called upon to deliver on that promise that very year through SCOPCE I. Whether the mental health field could "police" itself was by no means clear in 1974. Development of the national Professional Standards Review Organization (PSRO) system, created in 1972 to oversee Medicaid and Medicare claims, was bogged down in a legal controversy between the medical profession and the Government. It was also doubtful that nonphysician mental health professionals would be able to participate meaningfully in that system, since the law mandates physician-dominated review.

Several local psychiatric and psychological organizations had set up review committees to adjudicate questions about insurance claims, and pilot peer review systems were operational in some localities, but the national professional associations were then still in the process of developing standards, diagnostic criteria sets, and other prerequisites to peer review. When the CHAMPUS scandal erupted, the state of mental health peer review was largely unidisciplinary and spotty.

Obstacles to establishing a workable, national, multidisciplinary system were formidable. For example, peer review poses a potential threat to providers of services. Financial incentives in a fee-for-service reimbursement system tend to encourage providers to hold on to patients rather than to "cure" and terminate them as quickly as possible. Hence cost-conscious third-party payers question the credibility of information submitted to the peer review system by providers.

In the December 1974 *American Journal of Psychiatry*, psychiatrist Donald Newman and quality-assurance expert Lorraine Luft discussed this issue faced by a peer review system if it attempts to police rather than simply educate providers:

> If professionals feel that the atmosphere is punitive, they cannot help but become defensive. Then, instead of getting a cooperative, open presentation of material, we would have therapists presenting cases to us in a defensive and even manipulative manner in order to ensure themselves a "good grade" within the reporting system. Clearly, if information is withheld from the reviewers or is distorted, the peer review system would no longer be an appropriate mechanism for making clinical decisions. In short, one cannot act on the information received in peer review without forever altering the ability to acquire that information, for the very atmosphere that allowed the information to become available would then be altered.

The authors observed that peer review is regarded by practitioners and insurance managers alike as a tenuous compromise, the former feeling that they are being interfered with and the latter doubting that providers can monitor their colleagues' practices.

Other psychiatrists, writing in the same issue of the *Journal*, took a more sanguine view. But all agreed that mental health peer review presents special problems. Drs. Donald Langsley and George Lebaron, Jr., pointed out that payment for mental

health services, unlike general health services, is usually related to time rather than procedures: "Time thus becomes negotiable as an important variable in both quality assurance and cost containment. Therapeutic approaches that spend time cost more money and will be discouraged by third-party payers unless strong evidence can be presented to support the 'need' for these services." Psychiatrist Benjamin Liptzen called attention to the dearth of knowledge then available about mental health quality assurance. Among contributing factors he cited: poor recordkeeping; lack of explicit criteria for diagnois, hospitalization, and discharge; and "fudging" innocuous diagnoses to protect confidentiality.

Indeed, confidentiality concerns pose difficult dilemmas for mental health providers. A primary condition of psychiatric treatment is the privacy of the patient-therapist relationship. A violation of privacy in the review system could jeopardize a patient's livelihood. Yet the reviewers, if they are to make meaningful judgments, must be privy to "confidential" information about the patient's condition, progress, and prognosis.

The problem of "fudged" diagnoses was later underscored in the NIMH MANDUCS (Mental and Nervous Disorder Utilization and Cost Study). Complaints about violation of confidentiality can arise even when care is taken to "sanitize" information to protect claimants' identities and when only aggregate statistical data are sought. Concerned over what appeared to be overutilization of mental health benefits in the Washington area (twice the national average), the Blue Cross/Blue Shield Plan for Federal Employees in 1976 required area providers to file a special mental health report form when billing for mental health services. The form asked questions about diagnosis, degree of impairment, and prognosis. The NIMH helped develop the form and processed the data collected from it in hopes of developing criteria for peer review. Shortly after the start of the project, the form had to be changed with three questions deleted after provider and consumer groups complained that their privacy and confidentiality were being violated.

Subsequent comparison of information submitted to the "Blues" with data on the same group of patients collected anonymously revealed widespread underreporting to the insurance plan of more stigmatized diagnoses, such as schizophrenia,

depression, and alcoholism. Less severe diagnoses, such as neurosis and "transient situational adjustment reaction," were overreported (Sharfstein et al. 1980).

"Legitimate concerns about confidentiality" render tabulated insurance claims data, such as numbers of visits and dollars associated with each diagnostic category, "of little value for peer and claims review purposes unless mechanisms can be developed to collect this information separately from personal identifying information," concluded a team of ADAMHA analysts (Towery et al. 1980).

Finding a consensus on norms for diagnosis, length of treatments, etc., is no mean feat in the ideologically fractionated mental health field. Schools of thought range from psychoanalysis to behaviorism, humanism, and numerous hybrids, each with its own following of practitioners. Providers with a psychodynamic orientation may advocate expensive, intensive, long-term treatment for the same case that a behaviorist or eclecticist might just as adamantly feel can be handled by short-term therapy.

Such were the challenges facing the mental health field's budding peer review capability in 1974.

CHAMPUS: A UNIQUE PROGRAM

Since the private sector has been reluctant to take the lead in insuring mental health care, publicly financed third-party programs have become the principal pioneers in developing mental health benefits. The U.S. Government has offered generous mental health coverage in AEtna- and Blue Cross/Blue Shield-sponsored plans to which more than two-thirds of all Federal employees belong. In the "Blues" plan, until 1981* mental health care was reimbursed at the same level as physical health care. The plan's high-option coverage paid 80 percent of outpatient psychotherapy bills. About 7.5 percent of all benefits went for psychiatric treatments which were used by around 1 percent of the subscribers each year. The relative stability of this utilization rate since the early 1970s was often cited as belying the notion that mental health problems are less predictable and riskier to insure than physical health problems.

*In 1981 the "Blues" plan reduced its level of mental health outpatient benefits by 10 percent to help defray the cost of introducing a dental benefit.

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Almost as large as the "Blues" Federal employees' plan—which with 6.5 million beneficiaries ranks as the world's largest premium-based health plan—is CHAMPUS. Some 6 million dependents of active-duty and deceased uniformed personnel, as well as retirees from the seven uniformed services and their dependents, are eligible for CHAMPUS benefits. The seven services include the Public Health Service Commissioned Corps, the National Oceanic and Atmospheric Administration Commissioned Corps, the Coast Guard, and the Marine Corps, as well as the Army, Navy, and Air Force.

Funds for the program are appropriated each year by Congress, principally from the Defense Department budget. The health plan is administered by OCHAMPUS (Office for the Civilian Health and Medical Program of the Uniformed Services) at Fitzsimons Army Medical Center near Denver, Colorado. Claims processing is contracted out to nine fiscal intermediaries around the country, usually private insurance carriers. The number of such fiscal agents has dropped from 47 during the mid-1970s.

The system works as follows: When beneficiaries use hospitals, clinics, or other health services approved by CHAMPUS, they sign a form authorizing payment. At the end of a billing period, the provider fills in the charges and sends the form to the CHAMPUS fiscal agent for that region, who pays the bill. The fiscal agent, in turn, is reimbursed periodically by OCHAMPUS.

After the program began offering virtually unlimited psychiatric coverage in 1967, mental health costs soared from 7 percent of all money paid out in benefits to 27 percent in 1973—more than three times the mental health share of the "Blues" Federal employees' plan. By 1973, hospitalization for mental health problems was consuming 40 percent of all CHAMPUS inpatient benefits.

Such seemingly runaway mental health bills were cause for alarm. However, CHAMPUS cost statistics are not easily compared with those of other health care financing programs, since CHAMPUS is not, properly speaking, a health "insurance" program. It is a supplemental medical "benefits" program. CHAMPUS subscribers do not pay premiums. They help pay only for services used—20 to 25 percent of charges for outpatient care after a $50 annual deductible, and 25 percent for

inpatient care (except dependents of active-duty members who pay only $25 or $5 per day, whichever is greater). CHAMPUS benefits supplement the direct medical care systems operated by the Army, Air Force, and other uniformed services. That is, a uniformed services family can often obtain health services "on base"—directly from a uniformed-service-operated hospital or clinic. Only when a needed service is thus unavailable are CHAMPUS benefits to be used. Accordingly, CHAMPUS data do not reflect the total health care utilization of service families. They contain disproportionately high costs for those types of services which are not commonly available on base—among them, mental health services.

Another source of distortion in CHAMPUS statistics lies in the fact that the program's beneficiaries as a group are not representative of the population at large. Wives and children and the elderly—who use certain kinds of services more than others—are overrepresented. A health benefits program supported by tax revenues, like CHAMPUS, may also operate on a philosophy different from that of an insurance plan which must ensure that benefits paid out do not exceed premiums paid in. Until 1973, the CHAMPUS program reportedly approved care without great concern about costs and accountability. The Health Services Directorate of OCHAMPUS was staffed by Army Medical Corps officers, many of whom apparently believed they were helping out their fellow servicemen by interpreting benefits liberally. Accountability-conscious personnel who took over the review operation in 1972 reported that they were frustrated in their efforts to reverse this longstanding policy.

Moreover, Congress, in setting up the CHAMPUS program in the mid-1950s, failed to specify any limitations on benefits—no price ceilings or maximum lengths of stay. In accordance with this "benefits philosophy," CHAMPUS has traditionally reimbursed patients for types of services and providers that other health plans have not covered. In the past, for example, CHAMPUS paid for such "nonmedical" services as special education and for such "nonessential" ones as orthodontics and cosmetic surgery. The plan reimburses for marriage and family counseling, unlike other insurers.

THE RTC BENEFIT

CHAMPUS was until recently the only third-party health program that offered coverage for comprehensive child psychiatric residential treatment. Other plans' inpatient benefits usually pay for care only in "bona fide" hospitals. Some pay for therapy conducted in an RTC, but not for the "nonmedical" room-and-board or educational and recreational components of such programs. Nonetheless, many child mental health professionals believe that the holistic approach of RTCs better meets the long-term care needs of certain emotionally disturbed children than does the more strictly medical orientation of most hospitals.

A 1976 NIMH survey identified 331 RTCs in the United States, compared with 24 psychiatric hospitals for children. Most of the RTCs are privately owned, while most of the psychiatric hospitals are run by State or county governments. In part because they do not have to meet State requirements for licensure as hospitals, RTCs cost less per patient day—on the average $47 versus $120 for hospitals (Witkin 1977). During 1975, 28,199 children were treated in residential treatment centers at an average annual cost of $23,814 per child.

A relatively recent innovation in psychiatric treatment, RTCs experienced a period of rapid growth during the late 1960s and early 1970s. A number of different models developed, with varying treatment philosophies, organizational affiliations, staffing patterns, and fees. Some departed from traditional psychiatry and psychiatrists and emphasized the child's personal growth rather than the elimination of illness. Others developed along more traditional psychiatric lines. While many of the residential treatment centers operated essentially as businesses, some had religious or university affiliations. Many were based on an educational rather than a medical model. Some institutions that were actually private schools added a nominal psychiatric program to qualify for CHAMPUS benefits.

Through the early 1970s CHAMPUS failed to identify RTCs as a distinct class of facilities. It placed all programs providing long-term care (over 90 days) under the rubric of "psychiatric hospital" or "inpatient psychiatric treatment facility." No data are available on how many RTCs were on the CHAMPUS-

approved rolls or exactly how much money was paid to them in patient benefits prior to 1974. It is known, however, that by 1973 CHAMPUS had approved well over 1,000 psychiatric long-term care institutions for children. According to one CHAMPUS estimate, 460 of these were traditional psychiatric hospitals, 449 were RTCs, and 114 were day programs. More than 300 of the RTCs served primarily emotionally disturbed children and adolescents, according to the estimate. Other estimates put the number of CHAMPUS-approved RTCs during the early 1970s at 1,500.

The number of such approved facilities fell sharply to 486 just prior to the Senate hearings in 1974, after CHAMPUS began requiring RTCs to meet standards of the Joint Commission on Accreditation of Hospitals (JCAH).

Until 1974, CHAMPUS required only that RTCs be State licensed and possess a nominal psychiatric staff. Sporadic inspections of facilities were instituted in 1972, but CHAMPUS reported insufficient resources to mount a systematic monitoring effort. CHAMPUS, like other third-party payers, took the view that quality control and standards were the responsibility of the "community"—of the mental health field and State governments. However, most States lacked meaningful licensing laws, and some became havens for substandard RTC operations. In many cases, bogus RTCs circumvented State requirements. One Florida institution made infamous by the Senate hearings offered neither an educational program nor legitimate psychiatric treatment. Instead, it encouraged licentiousness among its troubled juvenile residents and subjected them to bizarre experimental treatments.

As for the mental health field, it was still in the process of developing standards for child psychiatric facilities through the Accreditation Council on Psychiatric Facilities of the JCAH. These standards did not become available until the summer of 1974. And even then, they too often proved ineffective in curbing abuses.

The Senate investigation found that privately operated residential treatment centers were "springing up all over the country," catering mainly to State and local juvenile authorities in search of "commerically operated jails" for delinquent adolescents. It was reportedly common for an RTC to charge CHAM-

PUS considerably more than it charged a State for the same care.

A 1975 General Accounting Office (GAO) study of the CHAMPUS RTC benefit found that one facility's monthly rate ranged from $850 to $1,500, while CHAMPUS was charged from $1,300 to $1,500 (U.S. Senate 1976). Another RTC charged CHAMPUS about $2,000 a month, compared to $400 to $1,600 for patients supported by State and county welfare departments. After having informed CHAMPUS that its $900-per-month fee included psychotherapy, yet another institution billed the Federal program additionally for such treatment, later admitting to the GAO that they did so simply because CHAMPUS would pay for it. The congressional watchdog agency also found that half of the RTCs it visited failed to collect the sponsor's (usually parents') share of treatment costs, thereby removing incentives for the sponsor to reduce length of stay and increasing the likelihood of rate hikes.

According to John Walsh, of the Senate Subcommittee, treatment plans were often vague, frequently with the expectation that the problem youth would stay in the RTC until his or her 18th birthday. Since CHAMPUS set no limits on length of stay, some children remained in centers for years, with little hope of improvement.

Typical of literally thousands of cases prior to SCOPCE I were the following:

Sex	Age	Diagnosis	Prognosis	Improvement	Years Funded
female	12	autism	grim	minimal	6
male	14	autism	poor	profoundly and functionally retarded	8
female	20	schizophrenia	poor	none needed	7
male	17	explosive personality	guarded	minimal	6

OCHAMPUS Health Services personnel in Denver were aware they were paying for sham operations or for unjustifiably long or unorthodox treatments such as megavitamin therapy or "therapeutic camping." They repeatedly urged termina-

tion of inferior centers and of cases who were not benefiting from treatment. But when it came to denying payments, it was simply the word of CHAMPUS against that of the facility. And CHAMPUS usually lost, bowing to the threat of litigation, court orders, or political pressure on DOD. A retired CHAMPUS policy official recalled that in the early 1970s his office in the Pentagon was often visited by attorneys lobbying for the RTCs.

Dr. Janet Rogers, an OCHAMPUS health services staffer, recalled her first onsite inspection of an RTC in 1972. In the months that followed, she and her colleagues were to pay many such unannounced visits. Her suspicions aroused by a pattern of problem claims referred by the fiscal intermediary, she discovered upon her arrival at a Texas institution that it was licensed not as a children's facility but as a nursing home. The improvised children's unit turned out to be inadequate in program, staffing pattern, and physical plant. She noticed a mentally retarded girl with severe muscle spasms who clearly needed physical therapy but was not getting it. Although the center had assured OCHAMPUS that it had a physical therapist, it obviously didn't. Generally "horrified," Rogers returned to Denver and obtained authorization to wire the facility and the families of CHAMPUS beneficiaries residing there that payments would be stopped. But, according to Rogers, one phone call to CHAMPUS attorneys from lawyers representing the facility kept the center open for another 6 months.

"When we were finally able to close them up, the owners simply went down the road, bought another place, popped right back up as CHAMPUS approved, and collected several more thousands of dollars," she commented. "At one point in time you were lucky to find 1 RTC out of 10 that was any good."

RTCs INVESTIGATED

In the fall of 1973, child advocate Kenneth Wooden, remembered by one OCHAMPUS official as "an outraged young man," began investigating CHAMPUS support of residential treatment centers. Then Director of the Institute of Applied Politics in Princeton, N.J., Wooden was researching a book on the noncriminal confinement of children, under Ford Foundation sponsorship. By early 1974, he had turned over some

shocking findings to the Senate Subcommittee on Government Operations.

According to Wooden, 60 percent of all CHAMPUS-funded RTCs did not exist prior to 1966, when the program first introduced mental health benefits (Wooden 1976). With the help of sympathetic OCHAMPUS personnel, Wooden was able to identify and visit some of the most flagrant abusers on the CHAMPUS-approved rolls.

Yet another "outraged" man, Senate Subcommittee investigator John Walsh, soon began following up Wooden's leads. Upon his arrival in Denver, the former FBI agent found the frustrated OCHAMPUS staff wary of aiding a probe that could embarrass their agency, yet privately welcoming a chance to help change "the climate."

"A lot of people laid their jobs on the line prior to the hearings, and I think rightfully so," later remarked Dr. John Meyer, a public health physician then on assignment to CHAMPUS from the Navy, who became the principal architect of the program's mental health quality-assurance efforts.

The Senate hearings held in August 1974 concentrated on abuses at two CHAMPUS-funded RTCs, the University Center in Ann Arbor, Michigan, and the Green Valley School in Orange City, Florida (U.S. Senate, 93rd Congress 1974). Under TV news camera lights, witnesses told of beatings, mock funerals, widespread use of drugs, and fraud in the CHAMPUS-supported facilities. The expose also unravelled in a series of newspaper stories during the week of the hearings.

The 1974 public hearings required the Pentagon to make a choice: The RTC benefit either had to be changed or scuttled. DOD decided to develop a plan for reforming the program. In a July 31 letter to the Secretary of Defense, Senator Jackson outlined four objectives of such a plan:

1. Assurance that institutions providing psychiatric care under CHAMPUS are thoroughly investigated before approval; that they are monitored regularly after approval; and that they are terminated immediately if they are found to be performing improperly.
2. Assurance that abuse and mistreatment of patients, particularly children, is not tolerated and that action to halt it is immediate and effective.

3. Assurance that treatment proposed for psychiatric patients is adequately reviewed by impartial authorities to establish its relevance; that it will be provided in an appropriate institution; and that the program of the patient is monitored in a timely fashion.
4. Assurance that the rates charged to CHAMPUS are fair and reasonable and that the claims submitted and paid for by the Government are legitimate.

The "climate" had changed. The hearings gave CHAMPUS a mandate and fiscal resources to bring about the needed changes.

THE INTERAGENCY AGREEMENT

In the reply of the Defense Department to Senator Jackson on September 9, 1974, Vernon McKenzie, Deputy Assistant Secretary of Defense for Health Resources and Programs, wrote that CHAMPUS coverage of psychiatric treatment had been a "relatively uncontrolled program element." He cited lack of standards and monitoring as major "failures" rooted, in part, in the liberal benefits philosophy of approving any care legitimized by a physician's signature. He pointed out also that a quality-assurance plan then being conceptualized to correct the RTC situation was "pioneering in nature" and very probably could set a "pattern to be followed in other CHAMPUS-covered psychiatric areas." In his next letter to Jackson, on October 23, 1974, McKenzie announced the SCOPCE I interagency peer review agreement with NIMH.

"The best thing we could do to exert some control over the system was to make sure we had the best people. So that when an RTC said 'no, we don't accept your denial of payment' and took us to court, they would have to go up against the guys who wrote the textbooks." (John Meyer, M.D., M.P.H.)

Negotiations had progressed rapidly between CHAMPUS and NIMH representatives who had begun meeting as early as 1 week after the Senate hearings. By September, the outlines of a two-stage RTC peer review had taken form, and an agreement was made: DOD would supply the funds—NIMH, the expertise. Acting primarily as a broker, the NIMH would enlist the leadership of the child mental health field to carry out the peer review, thus ensuring maximum credibility for its recommendations.

"The mental health disciplines had all sorts of ways of treating people; one group would not say the other group was wrong for fear that yet another group might say that they were wrong. You couldn't easily get a consensus among them on anything," explained Dr. John Meyer, in discussing CHAMPUS's strategy at the time. "The best thing we could do to exert some control over the system was to make sure we had the best people. So that when an RTC said 'No, we don't accept your denial of payment' and took us to court, they would have to go up against the guys who wrote the textbooks." Having the mentors of the child mental health field behind the decisions of CHAMPUS was viewed as a powerful deterrent to potential litigation.

After soliciting names from the various child mental health professional groups, NIMH selected Dane Prugh, M.D., a respected University of Colorado child psychiatrist to preside over the review effort of the six-member SCOPCE. Although the group was composed entirely of physicians—five prominent child psychiatrists and one pediatrician—the interdisciplinary nature of SCOPCE I was never in question. Prugh, a past president of the multiprofessional American Orthopsychiatric Association, was a staunch advocate of a united child mental health field and of multidisciplinary peer review.

On October 21, 1974, the Memorandum of Agreement which launched SCOPCE I was signed by NIMH and DOD. In Phase I, it called for teams of independent consultants to review records of 500 CHAMPUS-supported children in RTCs and to examine the propriety of their placements, quality of care, costs, and

length of stay. In Phase II, onsite inspections were added in an effort to corroborate the findings of the record reviews.

REVIEWERS BRIEFED

Owing to the urgency of the problem, the briefing meeting for SCOPCE I reviewers was scheduled on very short notice. Sixty-five leading child psychiatrists, psychologists, psychiatric social workers, and psychiatric nurses were invited to a meeting with an expectation that up to half might attend, based on past experience in attempting to elicit interest in peer review among mental health professionals. Surprisingly, all but one showed up.

Many of the consultants had not concurred with what they viewed as an arbitrary imposition of limits on psychiatric benefits (120 days inpatient/40 outpatient visits) earlier that year. (The limits had been rescinded just 2 months before the meeting.) But any resentment did not last long.

At the meeting, CHAMPUS presented medical charts of children and adolescents it was still supporting in RTCs. One of the records was that of a young woman who had been admitted to a well-known RTC at age 16 with a diagnosis of acute schizophrenia. She was provided with individual, group, and milieu therapy, according to a 1966 chart. "Great things were happening . . . . Unfortunately, we had the same chart from 1973," recalled one reviewer. "She still had acute schizophrenia, she was still receiving the same treatment, and CHAMPUS was still paying the bill and didn't know how to get out of it. After reading a few charts like that one, the reviewers began to recognize that CHAMPUS, far from being the villains, were the victims, and had been seriously abused for years," he added.

At their orientation session, the consultants determined that to carry out the reviews they would need much more information than the charts contained. They specifically requested that each case file include an adequate developmental history, family history, mental status exam, psychosocial evaluation, educational assessment, and information about the nature of the event precipitating institutionalization, the point in the

medical history that the patient regressed, and any past history of treatment and its results.

Great attention had to be paid to the finest detail. The reviewers were told that for each CHAMPUS child in an RTC who was selected for review in Phase I, OCHAMPUS would send copies of charts via registered mail to 1 of 12 (later 19) three-member review teams composed of a psychiatrist and two other mental health professionals. After they had agreed on the disposition of a case, the teams were to return the charts to OCHAMPUS by registered mail. The consultants would then be reimbursed for their time and expenses by NIMH, which as part of the interagency agreement had been provided with review funds by DOD.

Out of concern for confidentiality of patients' records, the reviewers urged that only "sanitized" copies of the charts be sent, with names of RTCs and physicians deleted. But they were informed that their trustworthiness would have to suffice, and that, if the peer review experiment were not undertaken, strong pressure would come to bear on CHAMPUS to eliminate the RTC benefit entirely. The reviewers themselves were guaranteed anonymity for the duration of the project; each was assigned a code number for identification when phoning in to OCHAMPUS recommendations about cases. No breaches of confidentiality were reported during SCOPCE I.

PHASE I: CHART REVIEWS

The request for information specified by the SCOPCE consultants was incorporated, with the help of NIMH statisticians, into a form which the RTCs were required to follow in submitting charts to OCHAMPUS. In addition to the items previously mentioned, case files were updated with specific information about treatment and medication plans, prognosis and anticipated duration of treatment, consultations obtained, parental involvement in treatment, diagnosis, and charges. The RTCs were given deadlines for submission of the information based on a child's length of stay. For example, information on children admitted between October 1 and October 31, 1974, was due by December 16, 1974.

The teams of SCOPCE reviewers, organized geographically, were to function as the third level of review in a three-level

review system. The first level consisted of OCHAMPUS clerks checking the information supplied by the RTCs to make sure it was complete. The second level, carried out by OCHAMPUS nurses, involved approval, denial, or termination of care, with an appeal offered.

"We evolved a philosophy of review which says that there can be no 'no's' [for proposed treatment] at lower levels. This is to protect the patient and the possibilities of creativity. The clerk can't say 'no.' The nurse can't say 'no.' Only the interdisciplinary panel can," explained Dane Prugh, chairman of the review committee. Criteria were developed for use by OCHAMPUS staff to "flag" questionable cases for referral to third-level review. These "flag criteria" (indications in the record of departures from usual and customary practice) fell into two categories: administrative criteria and care criteria. Any case "flagged" for not meeting care criteria was immediately referred to a SCOPCE review team. These were cases involving use of restraints, megavitamin therapy, shock treatment, psychoanalysis, more than three psychoactive drugs per day, more than two kinds of therapy per day, or more than three 35-minute visits with a psychiatrist per week. Cases "flagged" for not meeting administrative criteria typically resulted in a request for more information and eventual referral to a review team. These included cases involving patients in residence for more than 2 years; more than three admissions to the same facility within a year; more than three different facility admissions in a year; use of paramedical personnel for guarding or prohibiting a suicide; base costs greater than $60/day, $1,800/month, or $21,600/year; or additional therapy charges in excess of $200/month.

It was expected that one-third of the children in residential treatment for more than 2 years and one-half of those who were mentally retarded would be denied extensions of payments on administrative grounds because their charts would not show evidence of significant improvement. If the decision was appealed by the facility or the child's parents (or other sponsor) and a review team or appeals panel overturned it, payment was retroactive. In practice, the appeals panels concurred on disposition and disagreed only occasionally on length of time needed for discharge planning.

It took a while for the review teams to realize that neither they nor CHAMPUS could dictate the treatments an RTC provided. The reviewers' role was limited to recommending whether CHAMPUS should continue to cost-share for a given child in a particular RTC or whether referral to another kind of care should be made.

"The questions we asked were simple and straightforward," Prugh said. "Is this kid disturbed enough so that he belongs in a residential treatment center? Is he getting adequate treatments? If not, where should he go? Home? Day treatment? Group foster home? Outpatient psychotherapy?" SCOPCE developed a long list of alternatives to RTCs. However, CHAMPUS did not reimburse for all of them, nor were they always available in the child's community.

Often reviewers felt frustrated with the information provided by the RTC. They helped refine what Prugh called "increasingly angry" forms for the RTCs to fill out:

> We weren't getting the information. Gradually it became apparent that we weren't ever going to get it from some institutions. Those kids tended to get turned down. Those institutions didn't meet standards. The good places sometimes didn't produce very good responses, but as we asked for more and more finite responses, they gave them because they had it. They just hadn't organized their records. You could often tell an RTC's motivation from how cooperative it was.

Over time, SCOPCE I evolved forms explicitly designed to ferret out problem cases and facilities. For example, instead of simply asking for a treatment plan, SCOPCE I asked RTCs to describe in detail how a particular child's treatment plan related to his or her particular diagnosis. "It was learned that you cannot build a standard generally for this kind of care, that you have to ask and identify the question that will allow another person from the outside looking at the chart to be able to determine . . . that what has been described are the components of reasonable care," said CHAMPUS physician John Meyer.

OCHAMPUS usually sent 8 to 10 cases in a batch to a review team. Among the first cases reviewed were those appearing on the following page.

When Dr. Janet Rogers of OCHAMPUS analyzed the first 256 cases referred to SCOPCE I for review, she found that only

46 percent of the children and adolescents had natural parents living together. One-sixth of the parents were unwilling to have their child return home. Parents were involved in the treatment of 25 percent of the cases. One-fourth of the children's brothers and sisters also had a record of emotional disturbance. The RTCs diagnosed half of the children as suffering from either "transient situational disturbances" or "behavioral disorders." Eighty-two percent of the cases had received individual psychotherapy, 39 percent family therapy, and 27 percent drug therapy. Dr. Rogers' analysis also revealed that 40 percent had been in the RTC for a year or more.

Sex	Age	Diagnosis	Prognosis	Years Funded	Reviewers' Comments
female	16	depressive neurosis	guarded	2	needs another level of care with vocational training
male	16	childhood schizophrenia	fair	5	recommend 120 days for placement elsewhere; needs Special Education-vocational training; child abandoned by parents
female	14	adjustment reaction of adolescence	good	1	serious lack of information from facility; absence of historical events; unclear diagnosis; no description of bizarre behavior; further information requested but not provided

Sex	Age	Diagnosis	Prognosis	Years Funded	Reviewers' Comments
female	17	hysterical personality	moderate to good	2	continue care 20-60 days to obtain placement and outpatient therapy

Tufts University psychiatrist Dr. Arthur Mutter, who participated in SCOPCE I as a reviewer, sketched this composite case: A 14-year-old boy has been in psychiatric treatment since age 7. Early on, there were school misbehavior and learning problems. He might have been referred to outpatient therapy in an attempt at treatment, but this proved unsuccessful because his father had to move to another post and treatment would be interrupted. A year or two later, there was more "acting out," with the child getting into trouble with the police, drugs, and an increasing amount of behavioral disturbances. Disturbance in the family and its functioning was common. Different treatments were tried: psychotherapy, family therapy, medication. At some point, things just broke down completely and an RTC was suggested. "One had to rely on the record," explained Mutter. "If one has clinically seen enough children and knows enough about a child's history and the symptomatology, it's possible—unless the record is a complete fabrication—to get a sense of whether the treatment setting and the treatment being provided are appropriate to the pathology."

Another reviewer, Washington, D.C., psychiatrist Dr. William Stone, recalled RTC records which reflected a lack of understanding of a youngster:

> They were missing the boat. They were not seeing him as ill as he was. At times, suicidal potential was overlooked completely. The material was there. If you took a sophisticated look at it, you could see he was seriously disturbed. Yet he was being treated as if he were just one more child who happened to have come through there and it troubled you.

Despite their differing treatment philosophies and professional backgrounds, review team members were able to review

cases together and come up with joint recommendations based on what was best for the child. "There was a little friction. It created some heat. But more light than heat," concluded Chairman Prugh.

John Meyer of CHAMPUS concurred:

> We in the DOD knew what we were dealing with because we had been out there. The mental health people coming in had been referring these kids to the RTCs, and it was very hard for them to come to grips with the fact that they'd been referring them to holes. But the remarkable thing about that effort from the professional side was that people did put away their biases, their internal squabbles, and sat down and learned about what was going on in RTCs. I found it fascinating to see an outraged group of people. They were much harder on their own people than we would have been.

Initially, the teams urged denial of payments in 80 percent of the cases. Over time, as the most flagrant abuses were eliminated, this rejection rate leveled off at about 50 percent. Analysis of the first 256 SCOPCE cases reveals dramatic contrasts between facility and reviewer judgments of the children. For example, the RTCs gave nearly 67 percent of the cases a prognosis of fair to good, while the reviewers were that optimistic about only 6 percent of them. The RTCs urged that 55 percent of the children be permitted to stay in residence for an additional 6 months. In the reviewers' judgment, only 11 percent needed to remain that long. Thirty-nine facilities had aroused concern to the degree that onsite inspections were urged.

"The people who worked on SCOPCE I had to start thinking about how, in loose terms, a crook would think," said John Meyer, "how somebody bent on manipulating the system for financial gain—not necessarily morally but legally—would think." One clue the reviewers used to spot questionable RTCs was a pattern of taking children mostly from out-of-State. A reviewer explained: "It was very easy to identify problem institutions. They were the ones with kids from farthest away and lacking a community base. We became aware that a facility should be sharing its work, serving the local community, and taking only a certain proportion of CHAMPUS kids rather than being built solely for CHAMPUS." Such balanced facili-

ties were also better able to obtain family participation in treatment.

STANDARDS

During the winter of 1975, DOD, NIMH, and SCOPCE I worked together to smooth out snags in the review system. Since nothing quite like it had ever been attempted, much had to be improvised. The basic rules and goals of the project had to be reiterated to the reviewers. They also had to be reminded to supply the reasons for their recommendations. New forms were perfected. Reviewers, having come to the conclusion that too many children had been inappropriately institutionalized in the past, began discussing ways CHAMPUS might prescreen youngsters before authorizing admission to RTCs.

By late March 1975, SCOPCE's relationship to the JCAH became an issue. Surprise site visits by CHAMPUS had uncovered several JCAH-accredited RTCs in violation of JCAH standards. This problem had also been raised at the Senate hearings. The JCAH inspection system, based on site visits announced months in advance, was deemed inadequate to assure quality care. Once accredited, a facility would not have another JCAH visit for 2 years. The result was laxity in adhering to standards. In May, CHAMPUS embarked on its own set of RTC standards (backed by unannounced inspections) intended to supplement those of the JCAH.

"A lot of 'castles' were threatened by CHAMPUS doing its own thing with standards," John Meyer remarked. Yet the program had a Senate mandate to move into this previously off-limits area. Prior to the hearings the number of CHAMPUS-approved RTCs had been cut dramatically from about 1,300 to 450 when CHAMPUS began requiring accreditation by the JCAH Accreditation Council on Psychiatric Facilities Serving Children and Adolescents. This Council, composed of representatives of psychiatric professional associations and hospitals, charged facilities a fee for its evaluation survey. JCAH accreditation was originally intended to be more of an educational process than a monitoring or compliance mechanism. However, the Joint Commission began taking on a more official function beginning in the late 1960s, when Congress, in search of standards to write into legislation, relied on JCAH because it was

"the only game in town," explained Frank Rafferty, one of the initial consultants and reviewers who performed surveys for both JCAH and CHAMPUS.

The JCAH monitoring system has a focus different from that of CHAMPUS. Since CHAMPUS was paying for treatment on a child-by-child basis, it was interested in individual treatment plan monitoring. JCAH, on the other hand, concentrated on programmatic monitoring. Rafferty explained:

> The JCAH standards are all related to what the institution is like—physical plant, staffing, medical records, personnel policy, structure. There's no attention paid to whether a specific patient needs to be admitted, whether the treatment plan for that patient is a correct one, whether that facility is the place for that individual, whether he's been there too long, whether he should be discharged, what his plan after discharge is, what's going on with his family.
>
> As a JCAH surveyor, when you go into a facility, you really aren't too interested in the children. Sure, you're interested in them as people. You may even relate to them as you pass through. But you don't know any of their names. You don't know their problems. You might only casually become aware of these when reviewing their records. But you don't review the record of each case. You don't review it as an individual case. You review it to see if the physical exam is present, or the history is present, or working with parents is present. But you don't review it as to how that work applies to that individual. The JCAH pays no attention to charges. One of their standards is that the facility has to have an adequate budget for provision of quality service.
>
> As a CHAMPUS inspector, you knew the names of the 10 kids who were in that facility supported by CHAMPUS. You knew why they were there. You knew you were paying x number of dollars per day for that child. So you have some special concerns for his particular treatment plan.

Work on the CHAMPUS RTC standards began shortly after the Senate hearings gave the effort a green light in July 1974. According to Meyer, "the best" was culled from existing standards for children's treatment facilities—American Psychiatric Association (APA), JCAH, Child Welfare League, State govern-

ment—and amalgamated together in the spirit of: "Is this a place I would put my own kid into?"

In the year that followed, Meyer coordinated a far-reaching review of the draft standards by the three major service branches, mental health professional groups, and ultimately the SCOPCE. "The standards are not a summary of what is out there," added Meyer. "They reflect good medical practice, not good finances."

The best was culled from existing standards . . . in the spirit of: "Is this a place I would put my own kid into?"

As Janet Rogers observed, "The CHAMPUS standards attempt to reduce the areas in which subjective judgment can determine compliance or noncompliance. While the JCAH standards merely point out what should be done to upgrade the quality of care in an institution, CHAMPUS standards must be complied with if the institution wishes to receive payment from the Federal Government."

The standards reserve for OCHAMPUS the right to inspect an RTC and its records during normal working hours, any weekday, on an unannounced basis. Financial records must be made available upon reasonable notice. Uniformity in evaluations is optimized by requiring that central office surveyors approve all RTCs for funding. Reporting instructions are exceptionally specific, e.g., OCHAMPUS must be notified of any change in governance or senior staff within 7 days and immediately in case of emergencies, deaths, and AWOLs.

Staffing requirements are stringent: An M.D. must be available on a 24-hours-a-day, 7-days-a-week basis and must play an active and continuing role in the development and monitoring of the entire treatment program as well as each individual patient's treatment program. Coverage by active-duty military physicians is ruled out. RTC administrators are required to have had at least 5 years of experience in administering mental health facilities for children and/or adolescents. Preemployment references must be on file for all employees.

RTCs are required to protect all patients' rights guaranteed by the Constitution. Rights to counsel, privacy, and communication with family are spelled out in detail. Written policies are required on the methods used for control and discipline of patients and on the use of restraints and seclusion. Seclusion, defined as the placement of a patient alone in a locked room, must be ordered by a physician and must not be used simply for punishment. The patient must be checked at least every half hour, and a detailed log must be kept.

An RTC must have been licensed and in operation for 6 months before CHAMPUS will approve it, thus deterring creation of a facility solely for the purpose of obtaining CHAMPUS monies. Also, RTCs are required to continue their JCAH accreditation. "You can take any book of standards. They read so boringly. But almost each sentence, each word will be the tip of a detoxified iceberg, the tip of some major area of abuse that somebody dealt with somewhere, sometime," remarked reviewer and consultant Frank Rafferty in discussing the CHAMPUS standards.

SCOPCE chairman Prugh recalled that shortly after the standards were promulgated, he attended a meeting of the American Academy of Child Psychiatry in St. Louis. Six RTC operators complained that the SCOPCE standards were putting them out of business. Some did go under. But "the good places approved them," added Prugh. "They had no objection. They just said it's a lot of work, and that they have to spend some money on it."

A Committee of Reviewers and OCHAMPUS staff developed a formal participation agreement, a contract to be signed by each facility that wished to continue taking CHAMPUS patients. The document was designed to assure CHAMPUS legal grounds to terminate an RTC that failed to live up to the standards. Mailings containing the standards and the agreement then went out to all JCAH-accredited RTCs with CHAMPUS beneficiaries, notifying them of a March 1976 deadline for accepting the new rules. In all, 73 RTCs signed the agreement.

PHASE II: ONSITE CLINICAL EVALUATIONS

Whenever SCOPCE I reviewers noticed a pattern of problematic charts from the same institution, they relayed their con-

At 1974 press conference announcing SCOPCE I peer review (from left) NIMH Director Dr. Bertram Brown, SCOPCE I chairman Dr. Dane Prugh, DOD Deputy Assistant Secretary for Health Vernon McKenzie.

NEWS RELEASE
DEFENSE DEPARTMENT'S CHAMPUS PROGRAM
HEARINGS
PERMANENT
SUBCOMMITTEE ON INVESTIGATIONS
COMMITTEE ON
GOVERNMENT OPERATIONS
UNITED STATES SENATE
Overpayment to Institution Detailed
Laxity in Checking Facilities Admitted
The big business of unwanted kids
DoD Funds Psychology Peer Review Project
CHAMPUS
APA, CHAMPUS Enter Claims Criterion Pact
CHAMPUS peer review
from the field
Peer Review Project Said Successful to Date
MANUAL FOR OUTPATIENT CLINICAL PSYCHOLOGICAL CLAIMS REVIEW

cerns to OCHAMPUS, which then arranged for onsite inspections. During the latter part of Phase I, in the spring and summer of 1975, SCOPCE I consultants began accompanying OCHAMPUS surveyors on these visits. The practice was formalized in Phase II, beginning in October 1975, when an attempt was made to compare judgments made from chart reviews with onsite evaluations of the same children. The usual procedure was for two OCHAMPUS onsite evaluators and one SCOPCE consultant to travel to the locality of the facility the night before, check into a motel, and then notify the RTC by phone that it was going to be inspected the next morning. The SCOPCE reviewers concentrated on the therapeutic program, examining the clinical records, and meeting with staff and children, while the OCHAMPUS personnel assumed responsibility for checking out general medical practices, licenses, physical plant, financial records, and dietary matters.

Particularly during the earlier visits, reviewers had a unique opportunity to see firsthand the sometimes appalling conditions and practices of institutions that purported to be dedicated to the mental health of children. Many of the child mental health experts involved in the project had spent most of their professional lives working in excellent university-based hospitals and clinics and were not at all aware of the wide range of care nationwide. "The first reaction we CHAMPUS surveyors had was tremendous amazement and shock when we saw what people did," remarked Frank Rafferty. "When you get out into the field, you realize that there's a rather steep gradient, a very serious trailing off of quality as you move away from the major programs."

In a cover letter for her report of a July 1975 site visit to an RTC in rural Texas, SCOPCE consultant Dale Shaw, a Texas clinical nurse, remarked, "I'm still working through the intense feelings I have about the deplorable condition of that facility . . . . To think children have had to live in places like that and that we have allowed it to go on so long." Her report recounts a 4 1/2-hour drive across scorched desert to reach the facility, only to discover upon arriving that all of its emotionally disturbed children were off somewhere in New Mexico on a "therapeutic camping" trip. Meanwhile, the proprietor, who greeted the inspectors with "the gusto of an evangelistic minister," had turned the place into a lucrative dude ranch and

summer camp for normal children. This was standard practice each summer. The buildings were in shambles. There was no evidence of any medical program. Treatment appeared to consist of a pitiful token economy. "Since the medical records, treatment plans, credentials of staff, and physical condition of the facility were unacceptable, I urgently recommend that CHAMPUS withdraw all payment," wrote Shaw. "It is inconceivable to me that this facility could provide adequate treatment any time in the near future. The neglect evident at [name of facility] certainly indicates abuse."

An onsite evaluation report of an urban Texas RTC in March 1975 found "no evidence of any scheduled activity such as indoor games or crafts. Children were observed 'horseplaying.'" This RTC had a policy of requiring children who broke house rules to be stripped down to their underwear and confined. "One girl was observed in her room on 'underwear restriction.' She reported that she had been confined for 10 days. The director immediately released her. During her confinement, she broke out the glass in the windows in her room. The room was very cold since the outside temperature was 30 degrees."

After interviewing the children and finding the records inadequate and the staff unqualified, SCOPCE consultant Robert T. Long, M.D., concluded, "I would want no children of mine or of my friends to be treated by [name of facility]."

In his report on an August 1975 site visit to yet another Texas facility, SCOPCE reviewer Simon Auster, M.D., wrote: "While I am not particularly concerned with the elegance of the physical plant, the general quality of this one was captured in a medicine cabinet in one of the bathrooms, the inside of which was rusting, with shelves missing, and on the bottom of which rested an almost empty toothpaste tube, a toothbrush, a medication cup containing about half an inch of colored liquid, and two dead, half-inch-long insects that looked as if they had been there for quite a while." Calling the place generally "grim," Auster added, "My most serious concern about the program is the culture of violence which pervades it . . . . It is a bad scene."

In an Oklahoma facility full of insects, filthy bathrooms, and "slime on the floor," psychiatrist Arthur Mutter conversed with a 12-year-old boy:

> He obviously had been informed that there would be a visit from CHAMPUS and was very concerned. Initially he gave me a rehearsed speech about how he would have no place to go if he couldn't stay there. It was pretty clear that it was rote. After he relaxed a little bit, we started talking about the place, about what interested him and so on. In a very pathetic way, he talked about times when he came down for breakfast and happened to be one of the last kids down. Sometimes there wouldn't be any food left and he'd have to scrounge. He quickly started talking about the deprivation that he was supposedly there to avoid. This boy had been deprived much of his earlier life. And here, somehow, the Government had put him into a setting which recapitulated so much of what had been traumatic for him in the past. It came out in just a very pathetic way.

The consultants were also attuned to more subtle kinds of deficiencies. Psychiatric social worker Helen Warren, who visited an RTC in Connecticut, found that "it was impossible to discern how therapy was integrated into the remainder of the program or what the specific relationship of therapist to school was." As Warren observed in her report, "Boys wandered in and out of the director's office for snacks but were talked about rather than to. In the dining room, staff talked about a child who was sitting at the next table. In two instances, children approached the director with concerns and were dealt with in a perfunctory way."

Reviewer Frank Rafferty tells of a site visit to a generally respected RTC in Utah which had recently been visited and granted a 2-year accreditation by JCAH. The CHAMPUS inspection was prompted by a chart reviewer who stumbled upon a parental release form for a polygraph test inadvertently included in a chart of a youth in treatment there. Lie-detector tests are not an accepted element of psychiatric treatment. Rafferty learned upon his arrival that the polygraph tests were routinely administered to children after they returned from offgrounds leave to find out if they misbehaved while they were gone. If inappropriate behavior was detected, disciplinary action resulted.

Rafferty also discovered other questionable practices at that facility:

> They had a little room about 30 or 40 feet square in which they admitted all their patients. Physically it was all right, except that they had something like 25 kids in it. There were rules and regulations as to how people could get out of that particular room. They had to stand immobile and mute for discrete periods of time totaling 75 hours or sit the same way for a total of 150 hours. They called it "doing hours." Of course, you can imagine what the other adolescents would be trying to do to a kid standing in the middle of the room. They broke him up. And of course, he had to go back to the beginning and start all over again.
>
> Even if someone was totally docile and worked very hard at getting out, it took 3 months to get out of the unit. If a youngster resisted, he could be there 6 months or more. Since the program was such that they were not allowed outside in the yard—there were no windows in the unit—there were some very bad cases of skin disease as a result of being there. However, the line of parents waiting to put their children in that facility was very long. And even though the facility is no longer accredited by JCAH or CHAMPUS, the line is still long. In so many words they told us reviewers, "Shove off, we'll run our facility the way we want to. We don't need your money."

In Phase II, 25 centers in 11 States were selected for site visits. Each facility had many CHAMPUS beneficiaries. It was determined that the cost of a site visit could not be justified financially for centers with fewer than five CHAMPUS patients. Although initial analyses showed a high degree of correlation between recommendations based on chart reviews and those based on site visits of the same child, an attempt to conduct a controlled study failed. "The chart that was being sent in was always at least a month behind the condition of the patient at the time of the site visit," explained Meyer.

PREADMISSION SCREENING AND MONITORING PROGRAM

As the reviewers read charts and visited RTCs, they became increasingly preoccupied with the fact that many of the children should never have been in residential treatment. This recognition was cited as the main conclusion and "prime impact" of the SCOPCE I experience. During Phase II, SCOPCE

developed a proposal for a preadmission screening system that would keep as many children as possible in their own communities. Built into this scheme is a routine monitoring program designed to solve CHAMPUS data-collection problems and to assure quality care.

Under the proposed new program, CHAMPUS would not authorize RTC care until a local specialist evaluated the child to determine whether such placement was necessary. The evaluation could be done by a psychiatrist, psychiatric clinic, or community mental health center. SCOPCE urged that this evaluation and any resultant admission be undertaken during the summer months—"the time in a child's life cycle which most lends itself to a break in continuity with the school, the family, the courts, and so forth." The evaluation results would be reported to OCHAMPUS using a comprehensive form developed by SCOPCE for this purpose. The form incorporates the state-of-the-art know-how and screening criteria for RTC admission evolved during the course of the SCOPCE I project. For example, it contains the following itemized checklist of reasons justifying residential treatment:

- Presumed adequate intelligence to engage in psychotherapy
- Presumed adequate strength and assets to advance academically
- Need for structured controlled environment (family unable/unwilling to establish parameters of behavior)
- Lack of alternative resources (specify)
- Less-intensive/short-term psychotherapeutic intervention failed (specify)
- Harmful to self or others
- Need for long-term care (specify)

The evaluation form also contains a long checklist of alternatives to residential treatment, including options which would allow the youngster to remain at home and participate in programs such as partial hospitalization, outpatient therapy, day care, or vocational rehabilitation.

If the screener recommends against residential treatment, OCHAMPUS is to notify the parents (or other sponsor) and the affected RTC that the program would nct cover such treatment but might share costs of another recommended service. If the independent evaluation approves residential treatment, the RTC must submit a detailed treatment plan and information

form on the child to OCHAMPUS within 30 days. Upon receipt of this, the case enters a three-tier review system: (1) clerical, (2) nonphysician professional, and (3) SCOPCE review panel. As in the earlier system, any "no" decision would automatically elevate the case to the next level of review.

If care is approved, the child would be authorized to enter the RTC for up to 3 months. If a longer stay is needed, the request must again go through the three-level review system to obtain an additional 3-month authorization. If justified, OCHAMPUS could grant yet another 6 months or school semester of care, provided the RTC submitted progress notes and the information reporting form at 3-month intervals. If care is denied by OCHAMPUS at any point, reimbursement would continue for 30 days in order to give the facility or sponsor time to initiate alternative placement or to appeal the decision. The justification for extended length of care would have to be based on outside peer review at third-level SCOPCE.

The standards for psychiatric residential treatment centers developed by SCOPCE I were incorporated into the official CHAMPUS regulations in January 1977. Since then, CHAMPUS has from time to time called upon interdisciplinary teams of mental health consultants to review problem cases, but the preadmission screening and treatment planning provisions of the SCOPCE I recommendations have yet to be implemented.

COST-EFFECTIVENESS

By the summer of 1977, when it ended, SCOPCE I had reviewed some 1,500 cases at a cost of about $250,000. Although no controlled cost analysis of the entire project is available, the results of an actuarial study based on the first 800 cases reviewed during Phase I suggest that savings were substantial.

SCOPCE I yielded a benefit-cost ratio of at least 25 to 1.

The study, conducted by a team at the University of Denver led by accounting professor James Sorensen, projected an estimated savings of more than $5 million (Sorensen et al. 1980).

Sorenson estimated an additional $1 million in savings from curtailment of inappropriate admissions. Meyer later confirmed the reasonableness of these estimates in a 1977 analysis. At a cost of about $250,000, SCOPCE I yielded a benefit-cost ratio of at least 25 to 1 (Sorensen 1980).

SCOPCE I nearly halved the cost of the RTC benefit during its first year of operation, cutting it from $13.2 million in 1974 to $7.8 million in 1975 (see table 1). Between 1974 and 1975 the total number of CHAMPUS beneficiaries in RTCs dropped from 2,518 to 1,739. By 1977, this number had plummeted to only 204. Users of the benefit decreased 30 percent. Its cost to the

Table 1. Cost of Residential Treatment Center Benefit 1974–75

	CY 1974	CY 1975	Difference
Total Number of Beneficiaries in RTCs	2,518	1,739	-779 (-30.9)
Total Cost to Government for RTCs	$13,234,711.40	$7,789,345.60	-$5,445,466 (-41.1%)
Total Number of Admissions to RTCs	1,386	2,256	+870 (162.7%)
Average Governmental Cost Per Individual in RTCs	$5,256.04	$4,479.21	-776.83 (-14.7%)

Savings attributable to SCOPCE I peer review are reflected in dramatic drop in cost of RTC benefit.

Source: Sorensen et al. 1980

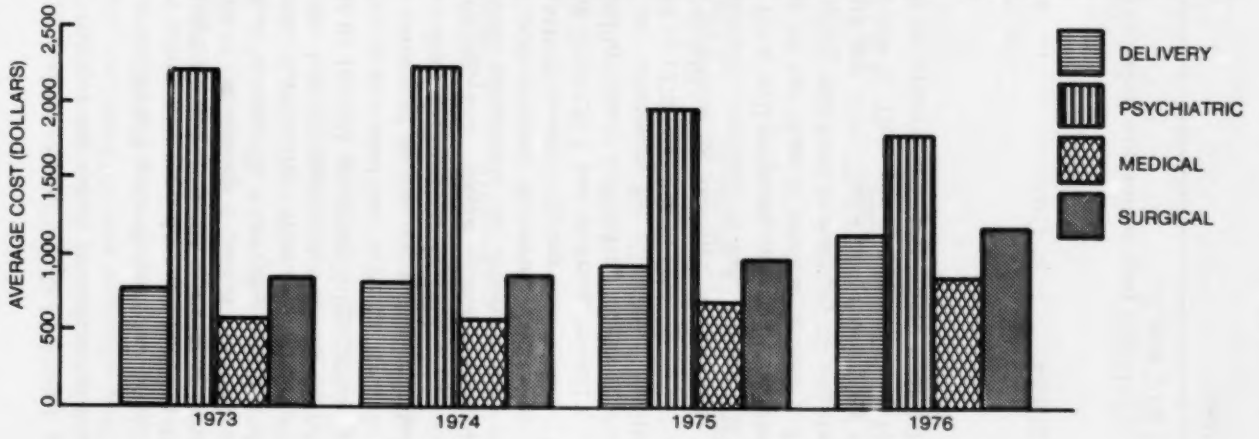
Government decreased 41 percent, and the average Government cost per individual in residential treatment dropped 14.7 percent.

The SCOPCE I peer review was probably the major single factor accounting for a decrease between 1973 and 1977 in total CHAMPUS mental health costs from $91.95 million to $90.20 million. This, during a period in which the average costs of national medical care services rose by 10.5 percent annually (General Accounting Office 1980). The average cost per admission for mental health services in CHAMPUS dropped from $2,216.04 in 1973 to $1,724.16 in 1976, while other major care categories escalated (see table 2). By 1978, mental health care costs consumed 16.2 percent of all CHAMPUS benefits, down from a high of 23 percent in 1973.

Treating four mental disorders—neuroses, schizophrenia, transient situational disturbances, and behavior disorders of childhood—rivaled delivering babies as the most expensive CHAMPUS benefits during this period. The CHAMPUS strategy in SCOPCE I was to bring mental health care costs under control by closely monitoring length of treatment. The average cost per admission for all mental health care was cut from $2,216 in 1973 to $1,724 in 1976.

To maximize its cost-effectiveness, peer review must be used selectively, according to John Meyer. "It takes about 20 minutes for a well-prepared case to be reviewed by an appropriate group on the issue of medical necessity. For every case you've identified, you have to multiply 20 minutes times 3 at so many dollars per hour. That's how much your system is costing you to review it. Then you can speculate as to whether the system takes an understanding of where your other utilization review

Table 2. Average Cost per Admission by Major Care Category FY 1973 – FY 1976



	Average Cost (Hospital and Physician)			
Deliveries	$ 762.80	$ 814.35	$ 941.53	$1,080.72
Psychiatric	2,216.04	2,230.61	1,936.03	1,724.16
Medical	522.51	554.77	680.21	821.21
Surgical (Includes Dental)	808.74	860.05	966.87	1,153.09
Total Inpatient	$800.66	$836.54	$934.27	$1,070.75

Dollar impact of SCOPCE peer review is reflected in declining average cost per admission for psychiatric care compared to rising costs for other types of care.

Source: John Meyer, OCHAMPUS

indices show you that your highest payoff is, in terms of dollars as well as probable areas of gross abuse."

SCOPCE I IN PERSPECTIVE

Both mental health and DOD personnel involved were generally pleased with the accomplishments of the SCOPCE I peer review experiment:

William Stone:

SCOPCE I taught a lot of us that it really was possible to do a multidisciplinary peer review. I had thrown up my hands at the whole idea of peer review until I got involved with this process. And then I realized that we really could police ourselves.

As we got more sophisticated in looking at other people's words, we were able to allow them a lot of latitude in their style of practice and still spot abuses. It benefited both the child and CHAMPUS, and it was good for our profession.

Arthur Mutter:

I sometimes felt that I should be paying SCOPCE for the opportunity. I learned a lot and found it a useful experience in a personal way.

Dane Prugh:

We've hammered it out together, and I think it's a model that the disciplines can live with . . . . I think people came out with qualitative feelings that you can review charts and come to operational decisions that are fair to the child.

John Meyer:

I think we're now at the point where its's going to be very hard for some shyster to come in and rip off the system.

Norman Penner:

It helped me see in perspective what we really ought to be doing. We had to look at our program as providing not maximum but only optimum services.

What has happened to the hundreds of children cut off from CHAMPUS support as a result of SCOPCE I? No one really knows. CHAMPUS typically gave parents and institutions only a week's notice before stopping payments—not enough time to plan for alternative placement, according to Dane Prugh. The Denver psychiatrist said he regrets not having been able to incorporate followup mechanisms into the experiment.

Among those few children of whom NIMH was able to keep track, one teenage boy who had spent 13 years in a Texas RTC rejoined his service family, which had been transferred to Europe. SCOPCE reviewers had felt that he did not need RTC care and suspected that the family was trying to dump the problem youth. Another boy in residential treatment for 8 years ended up in a State mental hospital after a half-year stint with his widowed father and six siblings. Yet another was placed in a boarding home under religious foundation sponsorship by the RTC, which felt that returning home would prove too disruptive.

It is generally acknowledged that a number of worthy RTCs were purged from the CHAMPUS-approved rolls along with the hundreds of substandard ones. Some centers simply preferred to invest their resources in the treatment of children rather than investing in JCAH accreditation and complying with the increasing paperwork demands. Other centers refused to change their programs to fit the model of care embodied in the CHAMPUS standards.

Some of those centers that did become accredited have in recent years reaped an unexpected benefit: Commercial insurance carriers have begun reimbusing them.

"When we started this, some of us speculated that we didn't know of more than 50 or 60 really good residential treatment centers in the United States anyway," remarked Prugh. "Well, it turned out there are 73. So there are more than we thought. We discovered some good ones. But we knew damn well there weren't 1,300."

In Meyer's view, SCOPCE I succeeded as a multidisciplinary peer review because what was at stake was a "motherhood-and-apple-pie-issue as opposed to a financial-piece-of-the-pie-issue.

"This was an issue of kids dying—mentally, and in some cases physically," continued Meyer. "More important, it was kids dying in places the professionals didn't even realize they were dying in. They were embarrassed that this could happen in their own mental health community—that they, the leadership, didn't realize that they'd let it slip that much."

Above all, SCOPCE I demonstrated the feasibility of multidisciplinary mental health peer review on a national scale; it showed that mental health professionals are willing and able to police themselves. The project demonstrated the reliability and cost-effectiveness of a review system based on examination of case records and onsite inspections.

SCOPCEs II and III, and the APA PROJECTS

The success of SCOPCE I was crucial to the future of DOD's involvement in mental health quality-assurance programming, according to John Meyer. Within a year after the signing of the first interagency agreement, DOD and NIMH embarked on two more joint peer review ventures known as SCOPCE II and SCOPCE III.

SCOPCE II consisted of local demonstration peer review projects in the San Diego, California, and Norfolk, Virginia, areas devoted to examining psychiatric hospitalization of CHAMPUS-eligible adults with schizophrenia, the third most costly medical condition covered by the program. Unlike SCOPCE I, which was primarily "retrospective"—reviewing care already delivered—SCOPCE II reviews took place "concurrent" with treatment. A mental health coordinator visited the hospital within 24 hours of a CHAMPUS beneficiary's admission for schizophrenia. American Psychiatric Association guidelines were applied to check the criteria recorded for admission. If the admission was judged inappropriate, two members of an interdisciplinary peer review committee examined the records. If they concurred, the admitting physician had the right to appeal to the full committee. A final appeal to a unidisciplinary subcommittee was also permitted.

In the San Diego project, in which efforts were made to control costs as well as to assure quality through peer review, the number of admissions for schizophrenia and the average length of stay for other mental health diagnoses decreased at the outset. However, an evaluation later found no statistically significant effects on utilization or reimbursement for either the San Diego or Norfolk projects. Neither was deemed cost-effective because of the relatively small number of committee peer reviews actually conducted and the high cost of psychiatrists' time (Sorensen 1980).

The evaluation found that successful initiation of both projects depended upon leadership from well-respected members of the local psychiatric establishment. It also suggested that the results might have been more encouraging had the projects been wider in scope and longer in duration, permitting economies of scale.

SCOPCE III was intended to test a PSRO-type model of peer review. It was designed to extend the capability of CHAMPUS for review of inpatient admissions with other expensive mental health diagnoses—alcoholism, personality disorders, transient situational disturbances, and neuroses. However, SCOPCE III was never completed as planned. Instead, the DOD decided to work directly with the two major mental health professional associations to develop a nationwide system of both inpatient and outpatient peer review. In July 1977, the DOD signed contracts totaling more than $1 million with the American Psychological Association and the American Psychiatric Association to build separate review capabilities for psychiatrists and psychologists (Moore 1977; *Psychiatric News* 1977). A single multidisciplinary system was not considered feasible.

"Our role is to respond to the temper of the times in the mental health community," explained Meyer at the time.

> I have to deal with the realities. Publicly, a lot of people agree. Privately, I can't get that much agreement. Once the mental health community gets its act together, we can merely instruct our second-level reviewer to call one psychiatrist, one psychologist, and one social worker (or nurse or marriage or family counselor). But we won't do that until we can get around one single table the leadership of all those professional associations, and until they will jointly say that it's acceptable to their membership and will go back and have a vote.

Both APA CHAMPUS review systems required a couple of years to develop before they became operational in 1979 and 1980. "Flags" for screening cases and other criteria were agreed on and eventually incorporated into manuals for each of the three levels of review.

Even before reviews began for CHAMPUS in July 1979, AEtna Life and Casualty began referring problem cases to both APAs on a semiformal basis. The private carrier adopted most of the system developed for CHAMPUS. However, unlike the CHAMPUS system, AEtna's is "blind" both ways to protect the confidentiality of patients, providers, and peer reviewers alike. Using a uniform set of instructions, some 80 AEtna field offices routinely screen out potentially problematic claims from psychiatrists and psychologists and forward them to the company's medical director, Dr. William Guillette, at AEtna's Hartford, Connecticut, headquarters. He and his staff further review the case report forms and send those deemed in need of peer review to the appropriate APA in Washington after first removing all patient/provider identifying information.

Out of about 2,000 claims from psychiatrists received by AEtna each day, perhaps 50 reach Guillette. Of those 50, only about 1 is actually referred to peer review, according to Norman Penner, formerly of CHAMPUS, now director of the American Psychiatric Association's peer review project. Penner's staff sends copies of the anonymous case report forms to three psychiatrist reviewers in the provider's region. Reviewers are selected from a panel of about 350 designated by local APA affiliate societies. The reviewers, who are informed of each other's identities and phone numbers, mail their comments on clinical issues, and recommendations for length of treatment and/or requests for more information to Penner's office. After removing the reviewers' identities, Penner then forwards these materials to Guillette.

Taking the reviewers' recommendations into consideration, the AEtna physician decides whether to pay the claims in question. Or more typically, reviewers need more information, and updated clinical reports and requests for information go back and forth several times. Reviewers' comments and recommendations are forwarded to the provider along with notices of approval/disapproval.

Psychiatrists' claims for psychoanalysis are handled differently than other claims referred for review. Separate criteria established by the American Psychoanalytic Association have been incorporated into the APA peer review manual. Among other things, they require a more detailed case report. AEtna requires two members of the psychiatric panel reviewing a psychoanalytic case to be analysts. CHAMPUS stipulates that only one member of each panel be in the provider's specialty.

Guillette flatly denied only 4 out of a sample of 114 initial psychiatric cases that underwent peer review. For 89 of the approved cases he asked for updates after specified numbers of additional visits (30, 60, 90, etc.) In 7 approved cases of psychoanalysis, he requested updates after 1 year of treatment. In 12 cases, he approved individual psychotherapy while denying claims for unorthodox treatments, like megavitamin therapy or certain types of group therapy (Herrington 1981).

The low incidence of claims denials does not reflect AEtna's actual cost savings attributable to the review system, Penner and Guillette stress. Upwards of 2 percent of cases referred for review end voluntarily. The mere requirement that providers file clinical reports periodically and the knowledge that they are being monitored also encourages them to expedite treatment. For its investment in psychiatric peer review—$45 in processing fees per case plus fees of $50-$60 per hour paid to reviewers—AEtna buys, in effect, the imprimatur of the American Psychiatric Association.

While generally similar to the AEtna system, psychiatry's peer review program for CHAMPUS, which became operational in July 1980, differs in that fiscal intermediaries (FIs) directly refer problem cases to the peer review panels. A second-level reviewer in one of the nine FI offices, usually a nurse, chooses three reviewers from a list of psychiatrists in the provider's region. The FI knows the identity of patient, provider, and peer reviewers. Reviewers know patients and providers only by a code number assigned by the FI. To minimize risk of breaches in confidentiality, FIs separate their claims files offices from those that screen treatment reports.

The American Psychological Association's peer review program for CHAMPUS and AEtna has been evolving somewhat differently than its psychiatric counterpart. though both professions follow the basic three-tiered model pioneered in SCOPCE

I. The psychologists' approximately 400 reviewers were selected by a national advisory committee rather than by local affiliates. Members of review panels are not informed of each other's identities and make their recommendations independently. Review criteria are formulated in terms of goals and treatment plans rather than in formal diagnostic nomenclature. The psychologists' peer review criteria have been made public in the hope that they might provide a guide to practitioners (Claiborn and Stricker 1979).

"If you're able to make a small change that cuts across the middle range of providers, you get a major impact on the pattern of practice." (William Claiborn, Ph.D.)

These criteria go beyond just weeding out the relatively small number of fringe practioners who submit claims for questionable treatment regimes to affect the larger number of providers whose practices might benefit from some shaping by their professional colleagues. "If you're able to make a small change that cuts across the middle range of providers, you get a major impact on the pattern of practice," explained Dr. William Claiborn, director of the psychology CHAMPUS project.

Among the principles adopted tentatively by the psychologists is the relatively daring position that reimbursement for any given problem should ultimately be limited to the shortest and most efficient treatments that reduce a patient's functional impairment. As might be expected, this "efficiency" criterion poses a challenge to psychoanalysts and other therapists with a psychodynamic orientation who practice longer term treatments. "We're still struggling internally with the issue of psychoanalysis in our advisory committee," remarked Claiborn. "There are conflicting views about it. One is to do essentially what psychiatry has done, which is to give them [analysts] a different system—different questions to answer, different criteria. The other is that they have to be forced into the mold of everyone else, which makes it easier to apply an efficiency criterion."

Since a claim typically will not be sent for peer review until after 60 sessions, a major proportion of cases in the psychology review system will likely be for psychodynamic psychotherapy.

A study conducted prior to the inception of APA reviews, employing 171 of the psychologist reviewers, found that those with a psychodynamic orientation were "more positive in their ratings of psychodynamic treatment and more generous in their recommendations concerning the reimbursement of past and future care" (Cohen 1981*a*,*b*). The NIMH-supported research by Lawrence Cohen of the University of Delaware found also that eclectic/behavioral reviewers who examined fabricated records describing the psychodynamic treatment of a depressed client were more inclined to recommend that another treatment be used, that the client be transferred to another provider, or that the provider seek consultation with another mental health professional.

Each reviewer received one of six fabricated clinical treatment reports which varied on the length of treatment and the amount of progress reported. Among the 79 reviewers who reviewed the "case" at the completion of 60 sessions, 16 percent of those with a psychodynamic orientation recommended reimbursement of fewer than 80 total sessions, compared to 75 percent of behavioral and 74 percent of eclectic reviewers. Reviewers' theoretical orientations were also found to have more effect on the evaluation of 60-session claims than on 40-session claims. Among 89 reviewers who examined 40-session reports, 11 percent of those with a psychodynamic persuasion, compared to 71 percent of behaviorists and 42 percent of eclecticists, recommended reimbursement of fewer than 60 total sessions.

Cohen suggests that CHAMPUS could receive "highly variable" recommendations from psychologist reviewers, depending upon the ideological composition of each review panel. APA/CHAMPUS might develop explicit criteria for reimbursing long-term care instead of relying on reviewers' professional judgments. However, Cohen points out, not enough is known about the effectiveness of specific treatments for specific problems to issue empirically based standards.

Claiborn said his project attempted with mixed results to apply a state-of-the-science monograph on psychotherapy re-

search by Dr. Morris Parloff (1979) of NIMH to the formulation of peer review criteria. Claiborn notes:

> In peer review, the issue almost never turns on what is the diagnosis and what is the treatment indicated by the provider, but rather on how the provider describes the problem—on what they [the providers] say they're doing. So much of the research is unrelated. Peer reviewers have no way of determining what a therapist actually does; they must rely on what is written on the treatment report form. Providers shape reporting and practice to fit reimbursement. Even though a therapist may attempt to use an approved form of treatment, there is no assurance that he/she does it well.

Criteria for a peer review system cannot be built around diagnosis, in Claiborn's view, because of what he terms "complicit fraud" on the part of providers concerned about confidentiality. Some will understate the diagnosis—to attach the least severe-sounding, least stigmatizing label to a patient that will still bring reimbursement. The psychologists' system is based on other types of criteria: the therapist's ability to develop and present an adequate treatment plan, with a clear description of impairment, goals for treatment, treatment methods, and a statement of progress.

Such standards can shape practice, Claiborn believes. For example, as CHAMPUS reviews began in California in 1980, complaints began coming in from practitioners who were being threatened with denial of claims if they continued a certain widespread pattern of practice. One of the APA criteria states that a provider should not see several members of the same family with individual treatment plans. "When a therapist gets a legitimate patient, it's very easy to abuse the relationship to involve other members of the family in individual treatment," explained Claiborn. "If it is a family situation, it ought to be treated as such. If four or five members of a family are treated by the same therapist once or twice a week, he practically lives off that family. All one needs is about five of those families and one has an $80,000-per-year income. If other members of the family need individual treatment, let them get it from another provider."

While Claiborn anticipates that only about 5 percent of psychologists' cases will ever be "controlled" by peer review (Claiborn and Stricker 1979), any criteria that affect practitioners'

livelihoods are bound to raise objections. By the spring of 1981, some California practitioners were charging the review system with usurping their clinical prerogatives by narrowly and arbitrarily defining "proper practice" (Foltz 1981). Critics also complained about red tape in obtaining payments, intrusive reporting requirements, and breach of confidentiality. Some questioned the efficacy of document-based review and urged that the program not be extended to private carriers until it could be evaluated. One disaffected reviewer vowed "to do whatever has to be done to get this thing stopped." In short, the review system had suddenly been thrust into the vortex of intraprofessional politics.

"Our test hasn't come yet," Claiborn observes. "When it does, the question will be: Can we withstand the pressure from our colleagues out there who want unobstructed access to the bucks?" He doesn't yet know whether the criteria disseminated will turn out to be effective screens, or whether reviewers in the field will support them. If the system ultimately is reduced to a "rubber stamp"—a routine shuffling of paper that only adds to the cost of processing a claim—he's prepared to recommend that it be radically changed or eliminated. On the other hand, if the review effort yields higher quality care and/or reduced costs, he thinks it will represent "an appropriate evolutionary step out of the SCOPCEs."

CONCLUSION

Like the psychiatrists, the psychologists are being approached by a number of insurance carriers for peer review services. For the time being, the two professions are accommodating these requests and those of CHAMPUS independently of one another. While there is little pressure to implement John Meyer's dream of a single national mult' 'isciplinary system, the ideal ha- not been forgotten. AEtna recently issued a single treatmen+ eport form that represents a compromise between the form: the psychiatrists and psychologists developed for CHAMPUS. Also, the psychologists have proposed that the systems eventually be merged, arguing that except for use of medications, which remains the exclusive responsibility of physicians, the broad range of psychotherapies are the same no matter who performs them.

Still, there remains strong sentiment within each profession that members of other, albeit related, professions are not their "peers." There is also the problem of what to do about social workers and nurses. Social workers' cases are currently being reviewed by the psychiatrists under CHAMPUS. Marriage and family therapists' cases under CHAMPUS are reviewed by psychiatrists and psychologists who are also marriage and family therapists.

"If CHAMPUS were to say to us 'You've got to do it together,' we could," remarked psychologist Claiborn. But for the forseeable future he's content to develop his program as a unique demonstration project.

The continuing investment of CHAMPUS in mental health quality-assurance efforts has been vindicated dramatically in the program's cost statistics. The mental health share of total program expenditures dropped from 27 percent on the eve of SCOPCE I in 1973 to 16.2 percent in 1978. Remarkably, these dramatic savings did not involve arbitrary cuts in benefits. In fact, CHAMPUS has been working with more professional groups to expand mental-health-related benefits. For example, in conjunction with establishment of professional standards by the Biofeedback Society of America, CHAMPUS recently proposed to remove a specific exclusion and to institute coverage for biofeedback treatment of certain conditions. The negotiations which ultimately led to this potential biofeedback benefit began with an NIMH-convened meeting of biofeedback researchers and insurance industry representatives in 1977. These talks probably would never have developed were it not for the personal contacts and trust building between the health care program and the mental health field which began with the RTC scandal and SCOPCE I in 1974.

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